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PALESTINE REFUGEE PROBLEM:

Arab Refugees Rehabilitation Program - Health Aspects.

Any consideration of the public health needs of the Arab refugees must proceed from a recognition of the two phases of the problem - the present or temporary phase, when the refugees are living in camps and other makeshift "communities" and the period to come, when the will be moved into new areas for permanent resettlement. This paper will deal briefly with the health needs of the first period. Responsibility for this effort has already been delegated to various agencies which are working on the problem. Ability to make specific recommendations with regard to the latter, or permanent resettlement, period is limited by present uncertainty as to exact geographic resettlement sites, whether the refugees will be absorbed into existing communities swelling the present population or be set up in new communities; whether there are at present any health or sanitation facilities in the resettlement areas; etc. As it may be generally assumed, however, that resettlement will be made in underdeveloped areas, certain broad principles can be enunciated at this time, pointing up the overall public health needs which may be anticipated. The presentation of more specific recommendations must await determination of such details as countries of resettlement, distribution figures, sites to be utilized within resettlement countries, etc.

The broad program of economic development currently under consideration to facilitate absorption and rehabilitation of the refugees can be successfully carried forward only through full utilization of all available manpower -- of the refugees themselves as well as of the local population, where there is such. It has been conclusively demonstrated that there is a direct correlation between manpower productiveity and the level of health of the population. Effective manpower is basic to the successful economic development of a population. In turn, effective manpower is directly dependent upon adequate nutrition, protection from devastating disease, and the conservation of a good health status. It is imperative, therefore, that positive and constructive health measures be considered concomitantly with the various other facets of any resettlement program, in order that the optimum socio-economic results may be achieved.

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Background

In accordance with a resolution Assistance to Palestine Refugees adopted by the General Assembly on November 22, 1948, the United Nations, the specialized agencies of the UN, the United Nations International Children's Emergency Fund, the International Committee of the Red Cross, the League of Red Cross Societies, and other voluntary agencies have initiated emergency measures to alleviate the present health problems of the refugees. In compliance with the request of the General Assembly, the Secretary General of the UN appointed a Director for Relief of Palestine Refugees to administer the relief program. Funds allocated under this program will provide relief for 500,000 refugees for the 9 months from December 1, 1948 to August 31, 1949.

In order to coordinate plans for dealing with the health situation and to bring health services as far as possible under unified direction, WHO has appointed, at the request of all parties concerned, a representative who is attached to the staff of the Director of the UNRPR, at Beirut. Under his chairmanship a committee consisting of the three chief medical officers of the operating agencies -- the League of Red Cross Societies, The American Friends Committee, and the International Committee of the Red Cross -- has been established. This Committee will deal with matters of general medical policy and the distribution of medical supplies.

Notes on Current Health Status of Refugees

No accurate census of the refugee population is available at present. Estimates vary greatly but it appears that there are between 800,000 and 900,000 refugees. It is generally estimated that at least 58% of the population consists of children up to 15 years of age, pregnant women and nursing mothers and that only about 100,000 of the refugees are able-bodied men. Approximately 450,000 persons are collected in tents, barracks, or huts, i.e., in camps, and the remainder are in towns and villages.

Although official reports are meager, they indicate that the nutritional status of the refugees is better than had been supposed, but this varies widely in different areas.

Recent reports also indicate that at present measles, respiratory infections, skin diseases, dysentery, malaria, smallpox, and some of the enteric diseases appear to be the most frequent

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causes of illness. Smallpox is present in South Lebanon, where approximately 200 cases have been recently reported. It is known that smallpox is also present in East Palestine but no definite information is available. Measles is prevalent in some areas, especially in Gaza. The enteric fevers and amoebic and bacillary dysentery are endemic among the refugees and cases are constantly occurring.

The number of refugees in highly malarial areas is not known. There are approximately 15,000 refugees at Tyre, where epidemics of malaria occurred as recently as 1938. In addition, at least 150,000 are camped in various parts of the Jordan Valley, where malaria is reported to be prevalent. Thus, except for those situated in a few very dry areas, most of the refugees are living in potentially malarial areas. A survey of this area is at present being undertaken by a malaria engineer from the WHO.

In many areas latrines are non-existent and human wastes are deposited around the periphery of the camps, often polluting the water supply and creating a serious fly problem. Refuse is discarded indiscriminately.

All camps have been sited near water supplies, but the quality of this supply varies from potable water piped into the camps, to filthy surface pools and irrigation channels into which drain, during the rainy season, the human wastes from large surrounding areas.

Long Range Program

The assumption is made, and it is likewise urged, that the emergency program will continue and be expanded, if necessary, during the migratory period of the population and until the permanent settlement of the refugees is well underway. Long range planning, however, must assure that through the provision of adequate health services, the health of the populace be maintained at a level which will enable the maximum number of people to participate fully and effectively in economically productive projects. As health is indivisible, it is essential that the health programs which are developed make provision for adequate medical services and sanitation facilities in the housing as well as in the working communities.

Thus, where a new housing site is selected for the resettlement

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of refugees, the area should be free of potential health hazards or, if present, they should be eliminated. (In the past, many attempts at resettlement have failed because of the presence of insect vectors of disease, such as malaria-carrying mosquitoes, in the settlement area.) Provision must also be made for the development of such fundamental services as an adequate water distribution system and adequate methods for the disposal of human wastes. Beyond that, the program should include plans for the provision of necessary public health and medical care facilities, such as health centers and hospitals, and of the necessary professional personnel. It is assumed that any community to be resettled on a new site would be of considerable size. It would, therefore, seem highly desirable that such community should have the service of at least one doctor, one nurse, one laboratory technician, and one clinic with hospital facilities. Recognizing the realities of the situation in the area under discussion, however, any specific determination of the number and type of medical personnel and equipment needed must await actual selection of settlement sites, decisions as to numerical distribution of refugees, etc. At that time, more precise recommendations could be made which would take into consideration actual conditions to be met, the possibility of having one medical unit or clinic or hospital cover more than one settlement, etc.

Where it is determined that the refugees are to be absorbed into already existing communities, similar problems would develop. It is inevitable that their addition to the original population would tax existing housing and sanitary facilities, often already inadequate. Crowding, coupled with unsanitary conditions, would also increase the danger of disease dissemination.

Practically any work project directed to the economic expansion of the countries or areas, such as the building of roads, railways, irrigation systems, agricultural development, etc., must include within its scheme of development not only a program of medical care of workers but also provision for the prevention of disease and for labor camp sanitation, wherever such camps are established. This will not only increase productivity of the workers but will also tend to decrease absenteeism due to illness. Together, these factors should contribute substantially to reducing the overall cost of the project. For these reasons it is recommended

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that expenditures for necessary health activities in connection with work projects should be included as an integral part of the total cost of the project, and that the health program should be administered within the project's overall organizational scheme.

Again, the fuller development of health programs for specific projects or types of projects would depend upon the possession of information about the health hazards of the particular terrain involved, the insect hazards of the specific location, knowledge of the existence or lack of sanitary facilities at the site or along the route of the project, the numbers of men involved in the project, etc. As an illustration, however, it might be noted that a development project such as highway or railway construction may require the establishment of labor camps along the route of work. In order to insure the maintenance of a good health status, a camp with several hundred workers should have, in general, at least one physician, two or three nurses, one laboratory technician, and one sanitary inspector. Indigenous personnel should be employed, wherever available, or be trained to do some types of medical aid work, where not already so trained. This personnel could not only aid in taking care of illnesses and injuries of workers, but could also conduct health protection programs, including immunization of workers against certain communicable diseases, supervision of general environmental sanitation activities, etc. A small movable health unit within the camp should include facilities for out-patient care of the ill and injured, and there should also be a few beds available for the care of workers requiring hospitalization, isolation in case of a contagious disease. A small laboratory, to conduct routine analyses, would contribute immeasurably to the efficiency of the medical staff. Depending on the workload, the physician himself might be able to perform these analyses, obviating the necessity for employment of a laboratory technician.

Variations of this general plan would, of course, be developed for different types of undertakings and to suit the individual needs of the project.

Conclusions

The UN, its specialized agencies, and voluntary groups should continue their health activities during the present migratory period of the refugee population, intensifying and broadening their scope, if possible, and aiming toward the establishment of permanent public

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health services at the resettlement sites. Health units, providing assistance in maternal and child health, tubeculosis control, venereal disease control, control of infectious diseases, environmental sanitation, etc., should be established. These programs could be initiated by teams of experts, sent to the area for this purpose. In the interim, indigenous personnel could be trained to carry on and expand the health programs as the local governments gradually assume full responsibility.

A health program should be included as an integral part of all development projects, as it cannot be too strongly emphasized that the success of these projects will depend, to a considerable degree, upon the effective participation of the population of the area.

Where actual construction of health facilities, such as water filtration plants, water distribution systems, sewage disposal systems, health centers, hospital facilities, etc., is required, an IIAA type of program might be considered, where the financial or technical contribution of the local government might be in accordance with its existing resources, supplemented, where necessary, by project funds.

In the planning and implementation of health programs and facilities, careful consideration should be given to several factors which will affect the quality of the permanent results achieved. First, care should be exercised that the overall program planned and the facilities installed are related to the economic status of the country as a whole, and are within the ability of the country to operate independently at a future date. On this basis, an understanding should be reached whereby the local authorities will eventually take over the full operation and maintenance, on a permanent basis, of the health services inaugurated under the program. By this means some assurance can be felt that the time and money expended on developing these services will bring lasting benefits to the area. Also, care should be exercised that the methods and procedures instituted are adapted to local conditions, mores, and attitudes. Personnel with the necessary knowledge and experience to adapt health facilities to the peculiar health needs of the area are available, and should be utilized in the planning and initiation of these programs.

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